Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service 06/04/01, 06/05/01, 06/06/01, 06/07/01 and 06/08/01?
   b. The request was received on 01/10/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Letter Requesting Dispute Resolution dated 01/04/02
   b. HCFAs
   c. EOB
   d. Medical Records
   e. Letter from CARF dated 04/13/00
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. The provider did not respond to the Commission request for additional information. The Commission's case file only contains the Initial Request per Commission Rule 133.307(e). The Commission case file contains no carrier response. The findings and decision will be based on the documentation available for review.

III. PARTIES' POSITIONS

1. Requestor: letter dated 01/04/02
   "Per TWCC MFG the reimbursement for the work hardening program is $64 per hour 97545-WH-AP includes the initial 2hrs and 97456-WH-AP for additional hours up to 6hrs. Rehab 2112 is CARF certified and payment should be at 100%."

IV. FINDINGS

1. Based on Commission Rule 133.305 (d)(1&2), the only dates of service eligible for review are 06/04/01, 06/05/01, 06/06/01, 06/07/01 and 06/08/01.

2. The Carrier's EOB has the denial "F – PER THE TEXAS FEE GUIDELINE, REIMBURSEMENT FOR NON CARF ACCREDITED INTERDISCIPLINARY PROGRAMS ARE REDUCED 20% BELOW THE MAXIMUM ALLOWED FOR THE PROGRAM – THE PROCEDURE CODE IS BASED ON THE MEDICAL FEE SCHEDULE. IF ONE IS NOT MANDATED, THE UCR ALLOWANCE IS REIMBURSED FOR THE ZIP CODE AREA."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MAR$	REFERENCE	RATIONALE:
06/04/01	97545-	$128.00	$102.40	F	$128.00	MFG, MGR	The documentation indicates that the services were performed and billed properly. The provider is CARF accredited and should be reimbursed at $64.00 per hour, per MGR (II)(E)(5). The carrier reduced the bills by 20% as if the provider was not CARF accredited. The provider is due reimbursement as billed. Therefore, additional reimbursement of **$422.40** is recommended.
06/05/01	WH-AP	$128.00	$102.40	F	$128.00	(II)(C),	
06/06/01		$128.00	$102.40	F	$128.00	(II)(E)(4 & 5)	
06/07/01		$128.00	$102.40	F	$128.00		
06/08/01		$128.00	$102.40	F	$128.00		
06/04/01	97546-	$320.00	$256.00	F	$320.00		
06/05/01	WH-	$320.00	$256.00	F	$320.00		
06/06/01	AP	$192.00	$153.60	F	$192.00		
06/07/01		$320.00	$256.00	F	$320.00		
06/08/01		$320.00	$256.00	F	$320.00		
Totals		$2112.00	$1689.60				The Requestor is entitled to additional reimbursement of $422.40.

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $422.40 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 26th day of June, 2002.

Larry Beckham
Medical Dispute Resolution Supervisor
Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.